EXHIBIT 84

RETAIL PHARMACY QUESTIONNAIRE

Servicing Distributions Center(s) _____

Name / Phone Number of BDM or Account Manager: _____

This questionnaire is to be completed by the Owner and Business Development Person during an on-site visit

1. **Pharmacy Name:** _____
   a. **ABC Account number** _____
   b. **Pharmacy's dba (doing business as), if any** _____
   c. **Has the pharmacy ever operated under a different name?**
      i. **Yes____ No____ If yes, provide the Name:**
      _____

2. **If existing ABC customer:**
   a. **Has been customer of ABC: Years_____ Months_____**
   b. **Customer's current ratio of CS to Non-CS invoice lines % _____**
   c. **Customer's total monthly dollar purchase volume w/ABC _____**
   d. **Is customer a Primary_____ or Secondary Account_____ with ABC?**
   e. **Does customer have Prime Vendor agreement? Yes___ No___**
   f. **Is customer part of a Buying Group?**
   Yes____ No____ If yes, provide the Name: _____

3. **Pharmacy Address:** _____
   a. **City**_____
   b. **State**_____
   c. **Zip**_____

4. **Pharmacy Phone Number:** _____ **Fax Number:** _____

5. **Pharmacy Email Address:** _____

6. **Name of pharmacist –in –charge as it appears on the license**
   _____

7. **Is this pharmacy affiliated with any other pharmacy?**
   Yes____ No____ If yes, provide the following:
   Name: _____
   Address: _____
   Phone Number: _____**Fax Number:**_____

   Note: If there are additional affiliates please attach an additional sheet with the information

8. **Ownership type: Check one**
   a. **Sole Proprietor ____ Corporation_____ Partnership____**
      i. **Other** _____ **(describe)**
   b. **If corporation, state of incorporation**_____
   c. **If corporation, Chief Executive Officer** _____

9. **Owner(s) name:** _____

a. **Owner's dba (doing business as), if any** _____

10. **Owner Business Address:** _____

11. **Owner Phone Number:** _____ **Fax Number:** _____

12. **Owner Email Address:** _____

13. **Number of years owner has operated pharmacy** _____

14. **Is the Owner a licensed pharmacist?**
Yes____ No____

15. **Pharmacy DEA registration #:** _____

16. **State BOP license #**_____

17. **Has the Pharmacy ever had a DEA registration suspended or revoked?**
Yes____ No____ If so, give details (when, why, etc.)
_____
_____

18. **Has the Owner ever had a DEA registration suspended or revoked?**
Yes____ No____ If so, give details (when, why, etc.)
_____
_____

19. **Pharmacy NCPDP or NPI #** _____

20. **Is the pharmacy a member of any professional associations (NABP, NCPA, APHA, etc.)**
Yes____ No____ If yes, provide name(s) _____

21. **Does the pharmacy have any other certifications? (VIPPS -Verified Internet Pharmacy Practice Sites™, etc.)**
Yes____ No____ If yes, give specifics _____

22. **Does the pharmacy have any other licensure/registration (wholesale, repackager, etc…)?**
Yes____ No____ If so, provide copies.

23. **What percentage of the following describes the pharmacy's business activities?**
_____% Retail
_____% Long Term Care
_____% Compounding
_____% Infusion
_____% Other (explain) _____

24. **Check the following manners of receiving business and provide what percentage of the total business it comprises:**

Walk-In	**Yes____**	**No____**	**_____%**
Phone	**Yes____**	**No____**	**_____%**
Fax	**Yes____**	**No____**	**_____%**
Internet/Mail Order	**Yes____**	**No____**	**_____%**

25. Which state(s) does the pharmacy ship into (if any)? _____
_____

26. Is the pharmacy licensed for sales in all states it distributes to?
Yes____ No____

27. Are prescriptions written by physicians located in the state in which the patient resides?
Yes____ No____

28. How many prescriptions are filled daily_____; monthly_____?

29. Check the following types of products and provide the approximate percentage of products you expect to purchase from AmerisourceBergen?

HBA	Yes____	No____	_____% of total purchases
OTC	Yes____	No____	_____% of total purchases
Non-Controlled Rx	Yes____	No____	_____% of total purchases
Controlled Substances	Yes____	No____	_____% of total purchases
Listed Chemicals	Yes____	No____	_____% of total purchases

30. Check the following types of products and provide the approximate percentage of products you expect to purchase from other suppliers

HBA	Yes____	No____	_____% of total purchases
OTC	Yes____	No____	_____% of total purchases
Non-Controlled Rx	Yes____	No____	_____% of total purchases
Controlled Substances	Yes____	No____	_____% of total purchases
Listed Chemicals	Yes____	No____	_____% of total purchases

31. Please provide a list of names of all suppliers you intend to continue to use
_____
_____

32. Please provide a list of names of all suppliers you have used within the last 24 months_____
_____

33. Does the pharmacy expect to order more than 3,000 dosage units (tabs/caps) of Phentermine a month? Yes____No ____ If so, how much and why? _____
_____
_____

34. Does the pharmacy expect to order more than 5,000 dosage units (tabs/caps) of hydrocodone combination products a month? Yes___ No___ If so, how much and why?_____
_____

35. Does the pharmacy expect to order more than 5,000 dosage units (tabs/caps) of Alprazolam a month? Yes___ No___ If so, how much and why?_____
_____
_____

36. **If reason for "Yes" answer to questions 33 & 34 is "Pain Management" clinics/physicians, please list each prescriber with their DEA Registration number (attach separate list if necessary)** _____
_____
_____

37. **Does the pharmacy have a web site?**
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon establishing a web site.

38. **Is the pharmacy affiliated with a web site?**
Yes____ No____ If yes, provide web address(es):
_____

Note: If no, you are required to notify us immediately upon affiliating with a web site.

39. **Check the following types of payments the pharmacy receives for products and provide the approximate percentage of total payments:**

Private Insurance	**Yes____**	**No____**	**_____% of revenue**
Medicare/Medicaid	**Yes____**	**No____**	**_____% of revenue**
Cash	**Yes____**	**No____**	**_____% of revenue**
Other	**Yes____**	**No____**	**_____% of revenue**

If other, provide details _____

40. **Attach and date photographs of pharmacy building (2 of inside, including counter area & 2 of outside-front and back of pharmacy).**

OTHER COMMENTS/OBSERVATIONS:

I, as the Owner or [authorized representative or officer of the Owner], declare that I have completed this Retail Pharmacy Questionnaire and to the best of my knowledge and belief the information provided is true, correct and complete.

WITNESS:

AMERISOURCEBERGEN DRUG CORPORATION

_____
AmerisourceBergen Associate Signature

_____
Full Name (Print)

_____
Title

_____
Cell Phone Number

OWNER:

_____
Name of Entity/Person

By: _____

_____
Name:

_____
Title:

_____
Date: